BlueCross BlueShield Federal Employee Program

TAFINLAR
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tafinlar (dabrafenib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Tafinlar therapy continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will Tafinlar be used in combination with Mekinist (trametinib)? ❑Yes ❑No
4. Will the patient need more than 300 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ mg per day
5. What is the patient's diagnosis?
   ❑Locally advanced Anaplastic Thyroid Cancer (ATC) **OR** ❑Metastatic Anaplastic Thyroid Cancer (ATC)
   a. Does the patient have a documented BRAF V600E mutation? ❑Yes ❑No
   b. Are there any satisfactory locoregional treatment options? ❑Yes ❑No

   ❑Low-Grade Glioma (LGG)
   a. Does the patient have a documented BRAF V600E mutation? ❑Yes ❑No
   b. Does the patient require systemic therapy? ❑Yes ❑No

   ❑Metastatic Non-Small Cell Lung Cancer (NSCLC)
   a. Does the patient have a documented BRAF V600E mutation as detected by an FDA-approved test? ❑Yes ❑No

   ❑Resectable melanoma
   a. Does the patient have a documented BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test? ❑Yes ❑No
   b. Does the patient's melanoma have lymph node involvement? ❑Yes ❑No
   c. Will Tafinlar be used as adjuvant treatment after complete resection? ❑Yes ❑No

   ❑Unresectable melanoma **OR** ❑Metastatic melanoma
   a. Does the patient have a documented BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test? ❑Yes* ***(*If YES, please select answer below)*** ❑No
   ❑**BRAF V600K**
   ❑**BRAF V600E**: Will Tafinlar be used as a single agent (monotherapy)? ❑Yes ❑No

   ❑Unresectable solid tumors **OR** ❑Metastatic solid tumors
   a. Has the patient's condition progressed following prior treatment? ❑Yes ❑No
   b. Are there any satisfactory alternative treatment options? ❑Yes ❑No
   c. Does the patient have a documented BRAF V600E mutation? ❑Yes ❑No

   ❑Other diagnosis ***(please specify)*****:** _____
6. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective non-hormonal contraception during treatment with the requested medication and for two weeks after the last dose? ❑Yes ❑No

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Tafinlar (dabrafenib)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Tafinlar therapy continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. What is the patient's total daily dose (mg per day) of Tafinlar? _____ mg per day

4. What is the patient's diagnosis?
   ❑Locally advanced Anaplastic Thyroid Cancer (ATC)
   ❑Low-Grade Glioma (LGG)
   ❑Metastatic Anaplastic Thyroid Cancer (ATC)
   ❑Metastatic solid tumors
   ❑Unresectable solid tumors
   ❑Metastatic Non-Small Cell Lung Cancer (NSCLC)
   ❑Unresectable melanoma **OR** ❑Metastatic melanoma
      a. Will Tafinlar be used as a single agent (monotherapy)? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____

5. Has the patient experienced disease progression or unacceptable toxicity while on Tafinlar? ❑Yes ❑No

6. Will Tafinlar be used in combination with Mekinist (trametinib)? ❑Yes ❑No

6. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ****If YES***, will the patient be advised to use effective non-hormonal contraception during treatment with the requested medication and for two weeks after the last dose? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Tafinlar – FEP MD Fax Form Revised 7/26/2024